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New apothecaries: how pharmacists can protect their independence in the NHS

In this article **Darrin Baines**, part-time senior research fellow, King's College London, and **Catherine Hale**, lecturer in law and medical ethics, University of Birmingham, propose that pharmacists should adopt a new model based on the traditional roles performed by apothecaries.

Pharmacists perform a routine task for patients that could be carried out without intellectual guidance and regulation from politicians, academics or their peers.

When chemists and druggists first emerged during the mid-1750s, they were not constrained by government policies, philosophies of care or professional ethics. Indeed, they were simply independent proprietors who filled a gap in the market for medical services left by apothecaries, who started to favour diagnosis and prescribing to compounding and dispensing.

By joining the Pharmaceutical Society, chemists and druggists sacrificed commercial and personal freedoms for the benefits of professional association. Although this step was constraining, the passage of time has created further laws, regulations and codes of conducts for working pharmacists. Notably, both the inception of the NHS in 1948 and the introduction of the 1968 Medicines Act did much to limit the profession's freedoms.

Against this background, this article examines the philosophical constraints that different groups have tried to impose on pharmacy practice since Jacob Bell began the process of professionalisation. By examining different philosophies of pharmacy practice, we suggest that the existing approaches of traditional dispensing, pharmaceutical care and medicines management have limited shelf lives.

Scientific communities

According to Thomas Kuhn, scientific communities consist of practitioners of identifiable specialisms who have undergone similar educations and professional initiations.[1]

In the 1840s, Jacob Bell initiated a network of proprietor chemists and druggists who believed in standardised education and professional practice. Similarly, most pharmacy practice academics belong to an international community of scientists who have their own conferences, journals, textbooks and communication networks.

In keeping with Kuhn's ideas, Randall Collins argued that intellectual life often consists of a “small number of warring camps” whose members are stratified in the following pyramid structure:[2]

* Intellectual stars — one or two leading thinkers at the top of the field

* Inner core — small number of researchers applying this leading thinking

* Outer core — larger population of less committed researchers

* Transients — bigger group involved in research on one-off or invariable basis

* Audience and maybe recruits — existing and possible students of approach

In relation to pharmacy, history suggests that Jacob Bell was an intellectual star who worked with an inner core to initiate an intergenerational network of pharmacists.

For Bell, his original audience were members of the Pharmaceutical Society, while his may-be recruits were druggists who were not convinced of the benefits of professional constraint.

Due to Bell's brilliance, the dominance of this network continued almost unchallenged until the end of the 1939–45 war, when the apprenticeship system died and higher education became the professional norm.

As employees of universities and polytechnics, rather than the Society, the new breed of pharmacy academics that emerged during the post-war period could free themselves and their students from the ideological dominance of the Bell-initiated network. As a result, this new camp of thinkers had the opportunity to create the conflict and the disagreement over the appropriate role for pharmacists that Randall Collins believes necessary for productive intellectual life.

Professional paradigm

According to Kuhn, different groups of scientists often work in competing “paradigms”, which he defined as “the entire constellation of beliefs, values, techniques and so on shared by the members of a given community”.

The evidence suggests that the professional network initiated by Jacob Bell and that of UK-based pharmacy practice academics have developed separate, but increasingly overlapping paradigms. As this dynamic situation is complex to analyse, it is useful to refer to the work of Imre Lakatos, who explained that scientific communities work with clusters of interconnected theories similar to paradigms, which he termed scientific research programmes (SRPs).[3]

Theoretically, all SRPs may be characterised as having an unchangeable “hard core” consisting of beliefs and lists of “dos and don'ts” that are treated as irrefutable or set in stone by community members. For instance, apothecaries had the hard core belief that they should both prescribe and dispense, which involved diagnosis, drug choice, compounding and supply. In response, Bell consciously decided to adopt the contemporary French and German pharmacy model, which specified that pharmacists should specialise in dispensing.

Given this choice, the hard core of Bell's system was outlined in the original aims of the Pharmaceutical Society: “The Pharmaceutical Society is instituted, for the purpose of uniting the chemists and druggists into one ostensible, recognised, and independent body — for protecting their general interests — and for the advancement of pharmacy, by furnishing such a uniform system of education, as shall secure to the profession and the public the safest and most efficient administration of medicines.”[4]

Given that these aims were fundamental to Bell's original vision, they automatically became the centre around which the constellation of beliefs, values and techniques of the professional pharmacy network subsequently evolved.

Pharmaceutical care

Since they were open to influence from thinking from other subjects and other countries, during the 1970s pharmacy practice academics began to search for their own alternative philosophy. During the 1990s, the search was given a boost by the arrival on these shores of the concept of “pharmaceutical care”, promoted in the US by Hepler and Strand.[5]

Initially in the UK, pharmaceutical care was an idea, not a paradigm, because it started as an individual concept not a living constellation of beliefs, values and techniques. Although Hepler recently acknowledged that pharmaceutical care is not yet a complete philosophy, in 1993 the American Society of Hospital Pharmacists outlined its core: “The principal elements of pharmaceutical care are that it is medication related; it is care that is directly provided to the patient; it is provided to produce definite outcomes; these outcomes are intended to improve the patient's quality of life; and the provider accepts personal responsibility for the outcomes.”[6]

For pharmacists working within the Bell paradigm, the move to pharmaceutical care requires the relinquishing of many commercial and professional freedoms. For instance, Linda Strand clearly specifies that pharmacists working within this new framework should not dispense.[7] Given these fundamental beliefs, pharmaceutical care clearly conflicts with the inner core of the Bell-initiated paradigm.

Evolving NHS

According to Thomas Kuhn, identifiable communities of researchers focus on specific problems. For instance, the Bell-initiated paradigm focused on developing a professional monopoly over medicines supply, while pharmacy practice academics concentrated on extending professional roles.

While these two communities debated the future of their profession, at the end of the 1980s the government began to reform the prescribing side of the medicines supply equation. In an attempt to control the NHS drugs bill, the prescribing analysis and cost database was introduced in 1988, followed in 1991 by pharmaceutical budgets under the auspices of the fundholding and indicative prescribing schemes. With the introduction of new information and incentives, many prescribers became concerned with their drug costs and pharmacists began to be employed by the NHS as pharmaceutical advisers in many areas.

As this trend continued, the National Prescribing Centre (NPC) developed, prescribing cost management became a topic for academic study, and a community of interested practitioners and academics evolved. Like the pharmacy practice community, this emerging network of practitioners and researchers wrote their own articles and textbooks, held their own conference and developed their own beliefs, values and techniques.

As the network matured, the name “management of medicines” emerged, with the result that the loosely defined, but politically acceptable concept of “medicines management” appeared in “Pharmacy in the future” in 2000. Although pharmacists struggled to define precisely this new concept, the NPC clearly stated that: “Successful medicines management services will ensure that patients, professionals and the NHS get maximum benefit from the use of medicines. This development will require change to existing mindsets and services. Professional time is a scarce resource and there is a need to reconsider the way many people work. Developing medicines management services will lead to more effective use of both financial and staffing resources, whilst also achieving the wider goals set out in the NHS plan.”[8]

Despite attempts to claim that medicines management is simply a type of pharmaceutical care, the above definition suggests otherwise. At its core, medicines management differs from pharmaceutical care because the former treats pharmacists as an NHS resource who can be allocated in the same way as financial spending, while the latter respects their professional autonomy. Given this fundamental difference, pharmaceutical care gives pharmacists the freedom to form working relationships with patients regarding medicines use, but impinges on their right to dispense.

Medicines management, on the other hand, has no strong beliefs about the appropriateness of any particular task for the profession, but simply states that individual pharmacists should become resources at the disposal of the NHS. Given this intention, the new pharmacy contract is designed to give primary care trusts the powers they need to transform community pharmacists from an independent, self-directing group of professionals into controlled, dependent individuals.

Given that pharmacy practice can be organised in many different ways, acceptance of the new contract is acceptance of greater constraints on the ways the profession works.

The new apothecaries

Although medicines management unexpectedly appeared as the favoured ideology for organising pharmaceutical services, during this time supplementary prescribing quietly emerged as a new issue for pharmacy practice.

Initially, supplementary prescribing developed from a network within nursing, as a means of extending their professional roles and stopping the illegal administration of some medicines. Next, June Crown was chosen to respond to the issues raised by this network by chairing a formal government inquiry, which unexpectedly created the need for new legislation and appropriate NHS policy. Although the Crown

reports were published under a Conservative government with Labour policy-makers implementing their recommendations, supplementary prescribing was never mainstream policy for either party. Similarly, supplementary prescribing was never a major issue of debate among the main pharmacy networks before the work of June Crown. Nevertheless, since government-funded training has become available, a new network of practitioners and academics has begun to develop in this area.

Given the potential — and the problems — offered by greater prescribing rights for pharmacists, we predict that a new paradigm for pharmacy practice may soon emerge. As this developing approach will involve issues related to both prescribing and dispensing, we suggest the working title of “new apothecaries” for the paradigm that will emerge.

The rise of new apothecaries will require the revision of ethics, policy and funding because existing approaches to pharmacy practice only consider dispensing or controlling medicines use. Indeed, as the dual role of prescriber and dispenser becomes widespread, ethical, policy and financial dilemmas will arise that would not have occurred if pharmacists solely dispensed or managed medicines without supply.

In theory, prescribing and dispensing are tasks that can be performed under different philosophies of practice and care.

For pharmacists, their profession only came into being because Jacob Bell developed a clear vision that controlled the ways druggists worked. Although this paradigm convinced legislators to grant monopoly status to the profession, in recent years pharmacy practice academics and government policy-makers have questioned the continuing suitability of this approach.9 Similarly, it appears that members and employees of the Society that Jacob Bell founded have also began to doubt the relevance of his initial vision, and started looking elsewhere for ideas on the way ahead.

Against this background, pharmaceutical care offered much promise, but was pushed aside by government policy-makers who wished to increase the control NHS managers have over individual pharmacists. If this agenda comes to fruition with the acceptance of a new contract, the immediate future of pharmacy could see the death of existing models of pharmacy practice. As more control is gained over them, pharmacists will be viewed as NHS resources and be measured as inputs into cost-benefit calculations performed by primary care trusts. In response, frustrated pharmacists will search for a new practice paradigm that restores some of the freedoms and benefits professionalisation gave them in the past.

As a result, we conclude that a new model based upon the traditional roles performed by apothecaries may be the best way ahead if pharmacists wish to protect their personal independence within an evolving NHS. However, experience to date suggests that a new paradigm will only emerge if a community of practitioners and researchers actively adopt the development of a new apothecary model as a serious and sustained area of research.

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